National Collaborating Centre for Infectious Diseases

Centre de collaboration nationale des maladies infectieuses

National Immunization Strategy Summit

May 14 and 15, 2024

Meeting Proceedings

March 2025

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National Collaborating Centre for Infectious Diseases

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Note to Readers

One year after the 2024 NIS Summit, the 2025-2030 Interim NIS document (to be submitted for approval by the Conference of Deputy Ministers of Health in June 2025) has evolved to reflect significant developments, including acknowledgement of limitations in Indigenous engagement and renewed commitment to building stronger relationships with partners and experts that represent these communities and other groups at risk of health disparities due to social, economic or environmental disadvantages, ahead of the next renewal. These updates also respond to the gaps identified at the Summit and reiterated in this meeting summary.

Acknowledgements

Many people were involved in the work and engagement to renew the National Immunization Strategy and to gather 150 representatives for the two-day Summit held in Ottawa in May, 2024. Our gratitude is due to those who participated in the various consultations, with special consideration for those who attended the Summit. Thank you as well to members of the NIS Working Group and our colleagues at the National Collaborating Centre for Indigenous Health.

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Introduction

Importance of Immunization in Public Health

Immunization has significantly improved population health status by reducing incidence and prevalence of infectious and other diseases. Many diseases that were once widespread have now been classified as rare because of comprehensive and coordinated immunization efforts.

Overview of the National Immunization Strategy

The Public Health Agency of Canada (PHAC) notes that the National Immunization Strategy (NIS) was developed to provide a framework for effective interjurisdictional collaboration that improves the relevance, effectiveness, and efficiency of immunization programming across Canada. The Strategy aims to support jurisdictions' ability to manage challenges in meeting current and future vaccination needs of all people living in Canada.[1]

The NIS is intended to support immunization outcomes by promoting equitable access and routine vaccination coverage, as well as public and professional acceptance of recommended programs. It also serves as a framework for jurisdictions to identify and act upon common interests with consistent, equitable approaches to immunization planning, purchasing, delivery, and education. By establishing and confirming Priority Areas and Objectives, the NIS serves as the overarching framework for immunization in Canada. It guides efforts to align immunization programs and partners across the country and within PHAC, with the common goal of increasing vaccination rates, reducing vaccine-preventable diseases, and enhancing overall population health.

Objectives of the National Immunization Strategy Renewal Summit

In the fall of 2023, a process to renew the NIS for 2025-2030 began, with a review of the 12 Priority Areas, vision statements and objectives that have been the foundations of the strategy since 2016.[2] Federal, provincial, and territorial (F/P/T) partners and other key immunization partners were engaged in person and on-line, with the goal of updating the NIS, establishing an overarching vision, and reviewing the Priority Areas. A NIS Renewal Summit, held May 14 and 15 2024, brought together guests and organizations from across the country to discuss early revisions to the NIS.

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[1] Government of Canada. 2024. National Immunization Strategy. https://www.canada.ca/en/public-health/services/immunization-vaccine-priorities/national-immunization-strategy.html

[2] Government of Canada. National Immunization Strategy: Objectives 2016 – 2021 https://www.canada.ca/en/public-health/services/publications/healthy-living/national-immunization-strategy-objectives-2016-2021.html

National Immunization Strategy Renewal Summit

PHAC partnered with the National Collaborating Centre for Infectious Diseases (NCCID) and the National Collaborating Centre for Indigenous Health (NCCIH) to co-host the NIS Summit. NCCID and NCCIH led the content and format of the small group discussions. The National Immunization Strategy Renewal Summit was held in Ottawa on May 14 and 15, 2024 and hosted over 150 representatives from federal, provincial, territorial and First Nations, Inuit, and Métis organizations.

Goals and Objectives

The specific objectives for the NIS Renewal Summit meeting were:

1. To build on engagement with key immunization partners and stakeholders and move towards a shared understanding of the overarching Vision, Priority Areas, Goals, and Objectives for a renewed National Immunization Strategy for 2025-2030.

2. To identify priority areas of focus for the National Immunization Strategy, 2025-2030.

Initial Engagement

The May 2024 NIS Renewal Summit was the culmination of several months of engagement with diverse stakeholders. The initial engagement process included immunization experts (NACI voting members), those involved in immunization programming in the provinces and territories, First Nations, Inuit and Métis partners involved with the Vaccine Preventable Diseases Working Group (supported by Indigenous Services Canada) as well as ISC's Public Health Working Group on Remote and Isolated Communities, Native Women's Association of Canada (NWAC), PHAC program staff with subject matter expertise related to each of the Priority Areas, other government departments with immunization programs, key immunization partners like Canadian Pediatric Society and Canadian Nurses Association, and community partners aligned with the Immunization Partnership Fund.

Summit Participants

The full list of participants can be requested. Summit participants included:

- Provincial and territorial representatives from the Canadian Immunization Committee, and some Chief Medical Officers of Health;

- Key immunization stakeholders including those from the National Advisory Committee on Immunization and national health organizations with an interest in immunization (e.g., Canadian Indigenous Nurses Association);
- First Nations, Inuit and Métis organizations (e.g., First Nations Health Authority, Métis National Council; Pauktuutit Inuit Women of Canada), academics, and health organizations;
- Other government departments with an interest in immunization (e.g., Indigenous Services Canada, Health Canada, Canadian Armed Forces); and
- Representatives from the Vaccine Industry Committee.

Limitations

The summit benefitted from the input of F/P/T partners and other key immunization experts. It is important to note, however, that the consultations did not reach many First Nations, Inuit and Métis organizations or representatives. Additionally, experts with knowledge of other populations such as Black Canadians, persons with disabilities, and 2SLGBTQ+ communities, for example, were also not extensively engaged in the process. Both limitations were noted at the May 2024 Summit, and it is important to recognize and redress these gaps.

Overview of Summit Agenda

The full agenda can be found in Appendix A. Over the two full days, participants received presentations from PHAC on the history of the NIS, the consultation process completed to date as well as the proposed new Vision, and 12 updated Priority Areas with their goals and objectives.

First Nations experts delivered keynotes presentations on data sovereignty principles and engagement, the roots of vaccine hesitancy around the COVID-19 vaccine for Indigenous Peoples, and examples of excellent programs regarding vaccine delivery and information campaigns.

In three successive breakout sessions, groups of 20-25 participants discussed four Priority Areas at a time in great detail. This allowed every participant an opportunity to comment on the draft

of each of the Priority Areas. The conversations were facilitated to maintain an emphasis on the ways in which equity concerns relate to the content of the new Priority Areas.

Information Gathered at the Summit

Notetakers took detailed notes of the discussions in every break-out session, using a template. To get an overall sense of whether Priority Areas were close to meeting the perspectives of attendees, participants were asked to 'vote' on their agreement with the title, goal, and objectives of each Priority Area and the Overarching Vision using the platform *Slido*. While the electronic votes provided a sense of how each discussion went, the richness of information was in the notes taken in every session.

Using Slido, participants were also able to submit comments and thoughts on each Priority Area, providing a means for any additional thoughts to be added anonymously. During a breakout session, the comments were visible to other participants who were able to add their agreement with a statement with a "thumbs up" icon.

A debrief session was held with break-out session facilitators and notetakers at the end of the day to gather the important points from the discussions.

The following section provides details on the format and content of each day of the Summit.

Day 1 - May 14, 2024

On the morning of May 14, 2024, **Grandmother Irene Compton**, Saulteaux from the Keeseekoose First Nation in Saskatchewan, gave thanks to the rains, did a cleansing with sage to enhance participants' clarity and understanding, and drummed a song.

Opening Remarks

Claudyne Chevrier and Margaret Haworth-Brockman of NCCID co-facilitated the opening plenary sessions.

Welcome and Introduction **- Dr. Donald Sheppard,** Vice President of the Infectious Diseases and Vaccination Programs Branch, Public Health Agency of Canada.

Dr. Sheppard welcomed the audience and acknowledged the traditional and unceded territories of the Algonquin and Anishnaabe people.

He discussed the importance of the strategy and its history, noting it has been very effective. This is now the NIS' third renewal process; it was supposed to occur in 2021 but was delayed due to the pandemic.

Dr. Sheppard noted the pandemic shone a spotlight on immunization in the country and brought to light challenges and opportunities. It resulted in the largest vaccine rollout in Canadian history, and likely globally. Vaccine innovation pipelines are more robust now than ever before. Collaboration was built between and across jurisdictions, internationally, nationally, regionally, and locally.

The pandemic also exposed challenges. He indicated we are in a time of vaccine hesitancy, with confidence in vaccines threatened amidst an environment of vaccine misinformation, as well as in an environment of fiscal restraint at every jurisdictional level. The pandemic also raised issues about health equity. Dr. Sheppard stated First Nations, Inuit, and Métis peoples, immigrants, and people living in remote and rural areas did not have the same degree of support as other areas of Canada and various populations. He acknowledged these are challenges that need to be faced, which includes hearing diverse views and voices to understand lived realities.

Dr. Sheppard indicated that the NIS was being developed through extensive engagement and that the Summit was not the end of that engagement. He recognizes there will be questions about the resources needed to operationalize the vision for the immunization strategy, but the

focus now is on the vision itself. He asked the audience to think, talk, and be creative about ways to support immunization, noting that vaccination is the most important public health intervention in history, and that we are at a crossroads.

Setting the Stage **- Dr. Theresa Tam,** Chief Public Health Officer **of Canada**

Dr. Tam began by speaking about how vaccination is one of the most successful public health inventions of modern time, and how it has broad economic and social benefits. She also discussed the COVID-19 pandemic and its impacts within Canada, noting that the pandemic brought attention to vaccines and vaccination programs in a way that was unprecedented, and it is important to reflect on lessons learned to strengthen our vaccination systems. Dr. Tam also noted the pandemic accelerated advances in vaccine technology, and we have yet to realize the full potential of vaccines for other benefits in the future, such as in preventing cancer.

Dr. Tam also acknowledged that existing vaccine programs need support. The speed and reach of misinformation are increasingly undermining vaccine confidence. Our vaccination structures are encountering mounting pressures, including fiscal constraints and shifting priorities. She shared her vision for immunization in Canada, where everyone can experience the benefits of vaccines through equitable access across the life course. In this vision, there are opportunities for accessible and timely approaches, and vaccination works across the whole health system and with all health care partners and communities. She stressed that the best public health approaches are community-centred and support self-determination.

In developing the NIS, Dr. Tam stated we must draw on numerous sources of information, such as indicators of public health that encompass equity, better leverage social and behavioural sciences to understand the factors that influence vaccine confidence and collaborate with researchers to address knowledge gaps and apply lessons learned to programming.

Dr. Tam stated her vision for Canada's vaccination system can be achieved using a system anchored in tools and foundations that support vaccination systems, such as health policies, data, interoperable vaccine registries, and medical and digital technologies. We also need to address workforce capacity and financing, including economic analysis that supports decision-making about where resources should be directed. She emphasized that equity and Indigenous rights must be prioritized in vaccine decision-making and governance systems. Public health leaders can use these components as a framework for developing actions and plans that come after the development of the NIS.

National Immunization Strategy (NIS) Renewal Process **– Chantal Langevin and Althea House,** National Immunization Strategy, Public Health Agency of Canada

Two staff members from the NIS Secretariat presented on the engagement methodology and the analysis process, stating the team engaged with a broad set of stakeholders including immunization experts; immunization programming partners within the provinces and territories; First Nations, Inuit, and Métis partners, including Indigenous Services Canada working groups; health professional organizations; and subject matter experts within the Agency.

A noted limitation to the process has been the tight timeline, which is a result of the delay forced by the pandemic. They indicated some jurisdictions and First Nations, Inuit, and Métis partners have expressed that longer timelines would have resulted in more meaningful engagement.

Consultation tools were developed based on the Pan-American Health Organization's tool, and feedback was analyzed from each stakeholder group to identify key themes. These led to the 12 Priority Areas proposed in the draft for this Summit. There was strong alignment across stakeholder groups regarding these priority areas. Once the NIS team looked at initial feedback, they consulted with subject matter experts internally and with the NIS Working Group members.

The 2013 NIS had stated visions aligned with each of the original 10 priority areas. These were reworked to have one overarching vision, with goals, key attributes, and objectives. The team saw several recurring elements and referenced them in foundational principles on the assumption they apply to all priority areas. The priority areas are articulated as "Canada has/is/does," with Canada referring to the country, not the government.

A number of communities and populations were identified as needing special consideration in the priority areas. Rather than trying to create an exhaustive list of these populations, the NIS team chose to include language around "populations experiencing inequities" rather than listing each of these populations repeatedly. The NIS team also heard from numerous partners that the objectives could be streamlined for clarity and based on this feedback the NIS team pared objectives down to 1-3 per priority area and increased the number of priorities from 10 (in 2013) to 12.

The speakers reiterated that the NIS team was looking for agreement in principle around priority areas and objectives and that all concerns would be recorded during the Summit. The

team will be incorporating engagement feedback – both from the summit and post-summit – into the drafting of the NIS, which will be circulated back to partners; this is anticipated to by the Spring of 2025. The team will then focus on lessons learned from this process and incorporate these lessons in the next renewal, which will begin in 2026/2027.

Keynote Presentations

The morning's keynote presentations focused on vaccination strategies that have shown success in the COVID-19 pandemic context.

The Importance of Indigenous Self-determination as a Vaccine Strategy **- Dr. Marcia Anderson**, Vice Dean, of Indigenous Health, Social Justice and Anti-Racism, Rady Faculty of Health Sciences, University of Manitoba

Dr. Anderson began by drawing attention to the World Health Organization interpretation on the right to health and its statement, "In any program, policy, and planning, we need to centre the needs of those furthest behind first." She noted that the process to date has run counter to this principle, as First Nations, Inuit, and Métis have said they need more time. She remarked that she disagrees that vaccine and clean water are most important public health interventions, as these issues are embedded in a colonial agenda. She pointed out that if our actions are not rooted in explicit decolonization and anti-racism, we will not be able to achieve Indigenous health equity.

Dr. Anderson noted that Indigenous health leaders have inherited problematic systems, as control and continued impositions from colonial governments continue to cause harms for Indigenous Peoples. She presented highlights from a Wahbung: Our Tomorrows Imagined presentation, which envisioned four scenarios of what First Nations health looked like as the pandemic evolved. She noted that these scenarios are a powerful way to understand the relationships and the processes we are using and is a useful framework for engaging with Indigenous Peoples in the future.

The Dominion scenario focuses on the dominant settler society and is the scenario we have inherited with the current health care system. She pointed out that during the pandemic, Indigenous health leaders provided a lot of advice about things that would not work, but the advice was ignored when developing public health orders and the orders were not effective.

In the Dreamcatchers scenario, the upheavals caused by climate change and the pandemic led to key innovations to respond to challenges stemming from short winter road seasons and remote geography. These included adoption of virtual care, virtual ceremonies to maintain

cultural connection, land-based activities, innovative ways to transport fragile vaccines, and remote learning. These innovations were better responses to the needs of First Nations communities.

The All My Relations scenario emphasizes a greater balance of power between First Nations and non-Indigenous partners. In this scenario, Indigenous health leaders began to work closely with non-Indigenous partners on an integrated vaccine approach, with Indigenous Services Canada, the Manitoba Government, and vaccine providers across many sectors.

The final scenario described was the Sun, Grass and Waters scenario. In this scenario, First Nations demand and achieve self-determination. It was represented by an information sharing agreement that was signed very quickly under the First Nations Health and Social Services Secretariat in Manitoba to achieve First Nations data sovereignty. As a result of this work, First Nations had daily First Nations specific data, including for status and non-status people, off and on-reserve First Nations, and urban Indigenous populations. As the pandemic progressed, the partners in decision-making, particularly the Manitoba government, began to trust First Nations health leaders even more. To achieve this trust, they used technology like weekly Facebook live feeds to share information regularly and be very transparent about what was going on in First Nations communities. They did not allow anyone else to speak to First Nations-owned data as they did not want non-First Nations people speaking to First Nations people and controlling the narrative.

Health outcomes were poorer for off-reserve First Nations populations, likely due to systemic racism and the existence of the same socio-economic disparities among off-reserve First Nations, including over-crowded living conditions and lower income levels. While severe health outcomes among the elderly were the focus of discourse in the general population, among First Nations, younger people had worse health outcomes.

Dr. Anderson pointed out that the key to successful implementation of the vaccination strategy in First Nations contexts was community control. She encouraged us not to move backwards from what we were able to do during the pandemic and default to Dominion scenarios just because of time pressures, emphasizing we will not be able to achieve health equity without being explicitly decolonized and anti-racist.

The floor was opened to questions however, no questions were asked.

***Auntie Cares! Helping Urban Indigenous Communities Make Informed Vaccine Choic*es - John Paillé,** Senior Communications Coordinator with the National Association of Friendship Centres (NAFC)

Mr. Paillé has led the NAFC's COVID-19 communication campaign since 2020. Mr. Paillé began by providing an overview of Friendship Centres. There are over 100 Friendship Centres and provincial/territorial associations (PTAs) across the provinces and territories that offer programs, services and supports to urban Indigenous communities. During COVID-19, these centres offered vaccine information, clinics, housing supports, and other services. The mission of the NAFC is to support Friendship Centres and PTAs in achieving their diverse missions and visions within their urban Indigenous communities.

The first COVID-19 communication campaign began in June 2020 with the Take Care in COVID campaign. As most of the information about COVID-19 excluded urban Indigenous populations, the NAFC partnered with Well Living House to provide culturally relevant information for urban Indigenous populations. This communication opportunities included webinars and social media content and allowed First Nations to ask questions.

The second campaign was My Vaxx Journey, which was targeted to youth and conducted in partnership with the National Indigenous Youth Working Group on Vaccine Uptake. This initiative focused on youth submitting videos in which they talked about their vaccine journeys. The NAFC received a donation of 150 Air Jordans (shoes), giving each youth who shared a video a pair of shoes.

The third campaign, Take Action in COVID, occurred from 2021 to 2023 and was funded through the federal government's Immunization Partnership Fund. It enabled the NAFC to provide culturally relevant information targeted specifically to urban Indigenous communities, including two webinars focused on vaccinations for adults and children, using influencers who shared their reasons for getting vaccinated to encourage others to do so.

The final campaign was the Auntie Cares campaign, which used an animated cartoon of Auntie to encourage kids to get vaccinated. One reason the character of Auntie was used is that in many Indigenous communities, aunties play an important role. In addition to social media, TV messages emphasized the importance of caring about communities, the higher risk of poorer health outcomes among Indigenous populations, and the need to protect community members. Messages were targeted not only on COVID-19 vaccination but also included flu and respiratory virus vaccinations.

Mr. Paillé also presented results from a NAFC survey, including that approximately 75% of respondents felt the campaign had the potential to positively change vaccine attitudes; 45%

felt the campaigns were instrumental in their desire to get vaccinated; 62% indicated the campaign helped educate urban Indigenous people about the importance of vaccines and dispel myths; and 87% agreed the information was easy to understand. The NAFC also analyzed social media analytics associated with the campaign and found that creative ad buys on social media were successful, with Facebook and Instagram having over 10 million impressions.

Breakout Sessions

Margaret Haworth-Brockman, NCCID, provided an explanation of the breakout sessions, where participants would meet in smaller groups to discuss each priority area and its various components, then vote via Slido on whether they agree in principle with the wording, agree with modifications, or do not agree.

Key findings from the breakout sessions are included in the section that starts on page 19.

Closing of Day 1 – Reflections on the Process

Margaret Haworth-Brockman thanked participants for their work during the day and invited comments.

A Provincial Health Officer remarked that she was struggling with the process and felt there was not enough time to raise fundamental issues and discuss how to address them for improvement. She felt the process was very rigid and a lot more thoughtfulness needed to go into the process.

She also commented that she was struck that, despite having Indigenous-specific sessions and speakers, there has been poor effort to do the necessary consultation leading up to the Summit and it has not been led by Indigenous people. She stressed that we need to ensure their involvement as their perspectives are needed to address structural barriers and racism.

Day 2 - May 15, 2024

Keynote Presentations

Medical Experimentation and the Roots of COVID-19 Vaccine Hesitancy Among Indigenous Peoples in Canada - **Dr. Jaris Swidrovich,** Assistant Professor, Leslie Dan Faculty of Pharmacy, University of Toronto

Dr. Swidrovich's presentation was an overview of a paper he published on medical experimentation in the Canadian Medical Association Journal and the roots of COVID-19 vaccine hesitancy among Indigenous Peoples in Canada. The article distinguishes between vaccine hesitancy and the questioning that Indigenous people have around vaccination in a colonial context. He commented that Indigenous Peoples are not inherently vulnerable but have been made vulnerable by a Canadian colonial policy regime that has guaranteed Indigenous Peoples have reduced access to adequate health care, food, and clean water, as well as experiencing socio-economic marginalization. All these factors increase the possibility of both contracting COVID-19 and having severe health complications. As a result, it is imperative that Indigenous Peoples receive priority access to vaccines, but vaccination must happen carefully.

Dr. Swidrovich told of examples such as forced sterilization on Indigenous women, nutrition experiments, vaccine trials, and a range of experimental surgical and drug treatments administered to Indigenous patients without their consent within the Indian Hospitals. These concerns, fears, and experiences have to be taken seriously and must be distinguished from anti-vaccination movements.

Legacies of racist paternalism have left Indigenous Peoples uniquely vulnerable to medical experimentation and abuse. This can be seen in the recent stories of Brian Sinclair and Joyce Echequan, who died as a direct result of racist treatment. They can also be seen in the testimonies of nearly 60 Indigenous women who launched a class action lawsuit seeking damages due to forced sterilization.

Dr. Swidrovich talked about the implications of having Indigeneity be a separate risk factor, using the example of influenza vaccines. Prioritizing Indigenous Peoples for vaccination without knowledge about Indigenous Peoples can lead to racism and stereotyping, when it is inequities in the social determinants of health that are the actual risk factors.

Dr. Swidrovich emphasized the importance of health professionals and policy makers to educate themselves before going into communities to administer vaccines, and that messaging about the risks of infection and benefits of receiving vaccine must clearly be positioned in a way

that speaks to Indigenous Peoples' historical and contemporary experiences with Canadian settler colonialism, and delivered directly by Indigenous elders, leaders, and health practitioners who have trust and credibility in their communities.

The floor was opened to questions; however, no questions were asked.

***Data Sovereignty Principles & Engagement with Indigenous Populations*: A Path Forward - Amy Nahwegahbow,** Senior Research Advisor, First Nations Information Governance Centre and Vanier Scholar, PhD student, University of Waterloo

The presentation began by noting that since time immemorial, Indigenous Peoples have skillfully met their needs by using the plants and animals for maintaining their own health. This knowledge was gained from centuries of accumulating knowledge and passing it down through the generations. Ms Nahwegahbow pointed out that recognizing diverse ways of knowing is important for cross cultural contexts like research and policy making to make sure all voices are heard.

Ms Nahwegahbow described the key differences between Western and Indigenous knowledges. Western knowledge is based on empirical evidence and uses scientific methodologies. Indigenous knowledge is based on traditional ecological knowledge, cultural practices and spiritual insight and is a historical knowledge that is shared by storytelling methods. Using both types of knowledge requires respect.

Ms Nahwegahbow defined Indigenous data sovereignty, noting that it is based on the right of a nation to govern the collection, ownership, and application of its own data, and to protect their traditional knowledge, cultural expressions, and intellectual property. Data sovereignty reflects the desires and interests of Indigenous Peoples to manage information according to their laws, practices, and customs. Indigenous authority and control over their data is a critical step towards realizing self-governance and fully exercising self-determination.

She also provided an overview of the First Nations principles of OCAP, which are a set of standards that establish how First Nations data can be collected, protected, used and shared. O in OCAP represents ownership. This ownership is distinct from stewardship. The C represents control, which means full control over data and processes, including all aspects of information management. The A represents access, which means First Nations can access the information and determine who else can access it. The P represents possession, which means physically holding and managing the data.

OCAP principles reflect First Nations commitments to use and share information in a way that brings benefit to the community, while minimizing any potential harm. The development of OCAP principles was spurred by past unethical research.

Ms Nahwegahbow also talked about key elements of engagement approaches with Indigenous peoples, and highlighted the importance of developing a policy within organizations and having a commitment to reconciliation and data sovereignty, pointing to the recent commitment made by the Canadian Institute of Health Information as an example. She argued that these approaches will help the effectiveness of the NIS strategy and lead to increased Indigenous vaccine uptake, while also fostering health equity.

Plenary Discussion

The moderator thanked the speakers and opened the floor for questions or comments.
One participant asked the speakers to comment on how aspects of the NIS can provide value to Indigenous communities, as noted by Ms Nahwegahbow in her presentation.
Dr. Swidrovich responded on the importance of using a partnership model. He stated that inviting Indigenous people into the process is one aspect, but they also need to have some control and be equal partners.

Ms Nahwegahbow responded that for herself and her PhD work, she went into the community and asked what members wanted as research topics. The community will be leading the research, and the project belongs to the community. She pointed out that this is the true meaning of data sovereignty.

A participant from the Métis Nation—Saskatchewan urged the audience to visit their website and read the "Métis vision for health" document, which summarizes Métis health priorities, including data sovereignty.

Summary from Day 1

Margaret Haworth-Brockman and Claudyne Chevrier provided a short recap on day 1 and stated all ideas, concerns and suggestions were documented by notetakers, in comments in Slido, in the results of the voting, in notes made during each session, and through discussions with facilitators. This information will be collated and integrated into the draft of the strategy.

Margaret also presented highlights heard at the facilitators' debriefing the previous evening and examples of comments received thus far, such as:

- An overarching theme was the need to dismantle and address systemic racism and the processes that do not serve First Nations, Inuit, and Métis as well as other populations, and integrating communities into the wording and implementation of the strategy, not just have them be involved or engaged.
- The overlap in priorities was causing confusion.
- A glossary of terms may be useful to include in the strategy.
- There was a disconnect between what the objectives state about implementation and who will be affected.
- Ethics in research and respect for data sovereignty needs to be considered.
- There is a need to clarify that there are different types of public health jurisdictions, not just federal, provincial, and territorial.
- Better coordination was needed between provincial and territorial systems and existing networks needed to be leveraged.
- There is a need to clarify the scope between routine vaccines and emerging and re-emerging vaccine-preventable diseases to address preparedness and interoperability.

She noted that the NIS strategy renewal team wanted to gauge the audience's perspectives on whether current wording for the vision was acceptable. Audience members were asked to vote in Slido whether they approved of the wording, did not approve, or approved with some modifications required.

The NIS strategy renewal team also wanted some indication from audience members on which areas of the strategy should be prioritized in the five-year strategy. Margaret asked audience members to pick their top five priority areas, not withstanding any concerns they may have about challenges or issues associated with the priority area.

PHAC Presentations

Centre for Immunization Surveillance — Vaccine coverage goals, and Centre for Emerging and Respiratory Infections and Pandemic Preparedness - Vaccine Preventable Disease reduction targets

Establishing vaccine coverage goals is one of the priorities of the NIS. The purpose of this presentation was to share information on the consensus process and timelines, the high-level plan for partners' and stakeholders' engagement, feedback received from the internal engagement, and next steps.

Most of Canada's NVCGs and national vaccine preventable disease reduction targets (VPD-RTs) were developed between 1994 and 2005 and then renewed in 2016, based on international standards and best practices. The goals and targets are consistent with Canada's commitment to the World Health Organization's disease elimination targets and Global Vaccine Action Plan, while reflecting the Canadian context.

To date, none of the NVCGs have been met except for achieving the 90% target of the tetanus, diphtheria, and pertussis booster by age 17 (92.8% in 2021). For the VPD-RTs, of the 13 targets, Canada has met nine, not met two, and it is unknown whether two others have ben met.

The 2025-2030 NVCGs renewal process consists of internal engagement, collecting partner feedback, and working group meetings. Drafting of the summary report for both the NVCGs and VPD-RTs will begin in December 2024 (TBC) and shared with TFWG members for review in January 2025.

The NVGC Renewal Team asks that the audience members give consideration to the following questions and provide them with feedback:

- Are there missing key elements from the planned approach?
- Is the planned approach for PT engagement and approval adequate?
- Is the list of stakeholders comprehensive enough?

The floor was opened to the audience for questions. One participant asked about what kind of validation was being done at the PHAC level on the survey instrument. The presenter stated that to some extent they are able to assess the validity of responses. She indicated that they are hoping to increase engagement with PTs in validating the registry but also know that registries are incomplete for all age groups across. She stated that there is no perfect answer for validation, but they are working with partners on this process. The participant responded by stating that we know that people who are anti-vaccination and

underserved populations have lower vaccination rates, so if the survey is not validated, key individuals are being missed.

Presenters reiterated that they are working with stakeholders to capture issues with vaccine hesitancy accurately and that a special path is being created for vaccine-hesitant individuals.

Plenary Discussion

A public health physician from Ontario commented on whether changes to national definitions are in scope. She found it shocking that administrative data is relied on for some childhood diseases. Presenters indicated that there will be discussion on case definitions and it is the intention to change some of them. This is a discussion that needs to be held with PTs, which requires resources, and we need to consider whether it is worth it to change the case definitions.

A physician from Manitoba, commented that it seems as if many of the targets are interconnected with immunization, and asked whether modelling is being undertaken to assess the implications of immunization targets and to assess certain coverage rates and outcomes. Presenters responded that modelling was conducted through the last renewal, especially with diseases of moderate incidence. They learned that this approach cannot be solely relied on to set the targets.

Presenters then asked the audience to reflect on the three questions posed earlier, and reminded the audience the list is preliminary and will include more Indigenous stakeholders. She indicated that they are happy to receive comments and feedback after the meeting or through the NIS team.

Identification of Five Priority Areas for Focus

Claudyne then showed preliminary results from the ranking of priority areas question posed earlier, as indicated by audience members as:
Priority Area #9 – vaccine confidence and uptake

Priority Area #5 – registry, coverage and records

Priority Area #3 – coordinated immunization schedules and programs

Priority Area #6 – vaccine safety

Priority Area #4 – program evaluation and research.

Breakout Presentations

Participants then chose to attend one of three concurrent breakout presentations:

1) Canadian Indigenous Nurses Association--First Nations, Inuit, and Métis perspectives on the NIS;
2) Centre for Immunization Surveillance-- FPT collaboration for vaccine Safety surveillance analysis/research; and
3) Centre for Vaccine Therapeutic Readiness and National Advisory Committee on Immunization-- Vaccine Pipeline, Public Health Technologies Strategy, and Biomanufacturing Life Sciences Strategies and the future of Medical Countermeasures Readiness in Canada.

The arts-based session was particularly well-received, with 75 attendees and feedback indicating it was a profound and valuable experience.

Closing Remarks for Day Two

Erin Henry, Director General for Centre for Immunization Programs at PHAC, and Margaret Haworth-Brockman offered some closing remarks and thanked attendees, panelists, organizers, and speakers.

Grandmother Irene closed the Summit with a drumming song called the "Travel Song."

Insights from Small Group Discussions on Priority Areas and Associate Goals and Objectives

Groups rotated through three rooms, discussing four priority areas (PA) in each room. This section provides summaries of what was discussed by all participants for each priority area.

Priority Area 1: Governance, Leadership, and Engagement

Some participants felt that the priority area needed to include wording on foundational commitments to Indigenous Peoples, given colonial structures. It was also noted that governance and leadership levels need to place emphasis on the structures causing inequities rather than people themselves, to address oppressive systems.

Revised Proposed PA1: Governance, Leadership, and Engagement	
Topic	**Points raised**
Commitment to Indigenous Peoples	• Indigenous leadership is required. As a non-Indigenous organization, PHAC cannot speak for Indigenous peoples. • Protocols of Indigenous engagement should be respected. • Governance structure is not only First Nations, but First Nations, Inuit and Métis. • First Nations, Inuit and Métis should have their autonomy, and not be seen as working against the NIS if they decide to not share data.
PA language	• Some terms or concepts are difficult to measure or too high-level, such as “effectiveness.” • Wording could identify ongoing engagement, collaborative governance, and specificity of what is being measured. • Reference to social determinants of health is missing.

Priority Area 2: Vaccine Guidance

Participants discussed the role and composition of NACI and felt it would benefit from greater diversity. They raised comments about the type of guidance NACI is being looked towards to provide. They also noted challenges and opportunities related to vaccine supply, purchasing, and use.

Regarding priority populations, participants questioned if there was strategic planning in place for collecting specific advice for those experiencing inequities. They noted ethics and equity was missing in the PA.

Revised Proposed PA2: Vaccine Guidance	
Topic	**Points raised**
NACI role and composition	• First Nations, Inuit and Métis communities could be included on NACI to better address inequities. • NACI reflects intellectual diversity, but should have greater cultural diversity among its voting members. • Direction on cost-effectiveness is needed, but noted that NACI does not need to be the body providing this direction. • NACI is being looked to for providing certain types of information and activity, such as knowledge translation and mobilization, but it is unclear what other groups are available to provide guidance for immunization products not covered by NACI.
Vaccine supply and purchasing	• Timelines are affected by product prioritization and are being driven by manufacturers; in turn, this affects purchasing. • There are lessons about procurement that can be learned from the pandemic. • Challenges arise when P/Ts act before NACI because of supply changes. • Off-license use of vaccines should be included in the NIS as this can improve program effectiveness.
Priority populations	• Specific populations should be involved in guideline development. • Revise wording to indicate oppression of underserved populations, instead of framing the issue as something experienced by the population. • Recognize there are data gaps about equity-deserving groups, which impacts ability to tailor guidance. • Reflect on whether NACI is well-positioned to make determinations about populations experiencing inequalities. • Identifying or grouping a “population experiencing inequity” may leave some populations behind and grouping at that level may prevent inclusion when it is necessary, and vice versa, as well as being dependent on the particular vaccine.
PA language	• “Equity-informed” attribute may not be framed correctly—consider that the federal government may be causing inequities in the first place. • “Cost-effectiveness” could be included, with a definition. • Knowledge translation could be an objective, and “evidence-based” could be a key attribute. • “Immunization authority” is unclear and can have a negative connotation.

Priority Area 3: Coordinated Immunization Schedules and Programs

Comments related to funding, the role of local political landscapes, and coordination were discussed. Participants raised challenges to harmonization across federal and PT jurisdictions for all VPDs' schedules and programs.

Some participants felt some of the PA content did not apply to Indigenous Peoples, as there are substantial differences in outcomes and needs, and it does not consider mobile communities or people living on federal land. There was also discussion about the meaning and appropriateness of the term "culturally safe."

Revised Proposed PA3: Coordinated Immunization Schedules and Programs	
Topic	**Points raised**
Funding	• A well-coordinated vaccine program can support rationale for further funding. • Free vaccines would bring all P/Ts into alignment. • Accompanying NACI recommendations with funding could be a solution for harmonization.
Challenges to harmonization	• Political landscape and funding in each jurisdiction would impact the ability to provide equal access to the same schedule. • Different P/T schedules undermine vaccine confidence, and should be reflected in this PA. • Immunization needs to reflect the jurisdiction's reality, and P/Ts should determine their own schedules based on local epidemiological data. • Feasibility of harmonization and coordination is unclear. • Harmonization cannot happen without funding. • Some VPD schedules could be harmonized, but not programs.
Priority populations	• Consider that Indigenous Peoples have a treaty right to health. • Cultural safety is inappropriate to include, as Indigenous organizations have been signaling that Canadian systems are not ready to address the priorities organizations have identified. • Consider that Indigenous Peoples and organizations are unique entities.
PA language	• Consider private immunizations that require Health Canada and NACI guidance. • References to flexibility at the local level could be added. • Consider incorporating some level of proportionality in the objectives.

Priority Area 4: Program Evaluation and Research

Wording and terms were discussed, and it was noted that more clarification is needed. Definitions would be useful. There were differing views on the use of some words, such as "culturally appropriate" and "equity."

Participants mentioned the need for accountability mechanisms, and that the PA could include addressing mis- and disinformation. It was also felt that evaluation needs to have an impact for decision makers, and that it should involve economic evaluation. The importance of research and evaluation needs to have more visibility.

Data usage with respect to both evaluation and research was discussed, with emphasis on the need to recognize Indigenous People's sovereignty, and the impact of colonization and the dominion relationship.

Revised Proposed PA4: Program Evaluation and Research	
Topic	**Points raised**
Affect the decision makers	• We need to bridge science with economic impact to relate to decision makers. • There should be mechanisms to embed policy advice in program evaluation. • Program evaluation should be regarded as a good investment. • The PA should mention the need for advocacy and how the government can shut down mis- and disinformation, and there should be accountability measures for those who spread misinformation. • Success depends on sustainability and coordination, including funding. • Referencing decision-making and guidance development is too narrow, as there is a continuum of evaluation, applied research, and methodological research.
Recognition and priorities	• Consider what is important for research over the short/medium/longer terms. • There is under-recognition of the expertise needed in research to achieve health outcomes, such as the social sciences. • Mis- and disinformation is not the only driver for research and evaluation in vaccination. • Vaccine confidence should be emphasized over vaccine hesitancy, as we need consistent terminology on drivers of hesitancy to ensure confidence and hesitancy are aligned.
Priority populations	• A cultural component is missing and will impact what is measured. • Engagement and partnerships from the outset is needed in research. A barrier of mistrust exists.

	• Indigenous groups should be referenced to avoid invisibility and ensure accurate representation.
PA language	• Equity and evidence require separate language. • The PA should also include specific mention of structural and systemic barriers, safety, and indicators.

Priority Area 5: Registries, Coverage, and Records

Participants generally agreed that a registry and immunization reporting would be beneficial, but were split on whether it would be best at the national or provincial/territorial level. They also noted challenges to implementing such an initiative within the day-to-day reality of public health roles. There was also discussion regarding data governance, system interoperability, and common data goals.

Revised Proposed PA5: Registry, Coverage, and Records	
Topic	**Points raised**
Data and technology	• Immunization reporting and registry should be mandatory. • It would be difficult to mandate a national registry, as "national" does not mean federal jurisdiction. • It would be difficult to achieve common goals and establish interoperable systems across P/Ts. • Consider that not all populations have equitable access to technology, and that reliable infrastructure is a concern in some areas. • If the strategy is a federal initiative, then federal funding for the initiative's infrastructure should also follow. • Data governance, privacy, and security need to be considered.
Priority populations	• Existing inequalities and lack of infrastructure make this initiative unrealistic for many communities.
PA language	• The term "Pan-Canadian" raises issues of trust for First Nations, Inuit and Métis communities. • Digital format is restrictive, and is inflexible for communities with accessibility issues or for individuals who prefer different formats.

Priority Area 6: Vaccine Safety

Discussion about vaccine safety linked it to vaccine confidence. There is a need to learn from protests and rallies against vaccines, and build trust.

Participants also spoke about the lack of awareness for reporting requirements, and more data about adverse events following immunizations would need to be accompanied with more knowledge translation.

Revised Proposed PA6: Vaccine Safety	
Topic	**Points raised**
Confidence is part of safety	• Issues seen during the pandemic about individual rights and privacy highlighted the need to provide people with confidence in vaccine safety without perceived overreach. • Safety monitors should be arm's length, view safety from multiple perspectives, and remember that people want vaccines to be safe. • A full vaccine safety lens goes beyond adverse events following immunization perspective. • The impression that Covid vaccines were created too fast and skipped steps in quality processes showed that providing publicly accessible data could inadvertently contribute to misinformation. • There may be conflict of interest if industry is monitoring vaccine safety, and there would need to be assurance and accountability to report in a timely manner. • Regulations and monitoring also need enforcement.
Data and reporting	• If more vaccine safety information becomes publicly accessible, it also needs to come with knowledge translation to maintain confidence and provide context—publicly accessible does not necessarily mean it is understood by the public. • Some providers are unaware of reporting requirements. • Training to build capacity with providers to be comfortable providing information on safety would be required. • The reporting process can be cumbersome. • There is potential to use existing systems for standardization, such as the BeSafe program. • Rare events need to consider the context and background. • Canada should have a more significant presence so rare vaccine safety signals can be shared and monitored globally. • Communication methods should be diverse.
Priority populations	• Education can empower Indigenous providers and community members.
PA language	• Guidance around data could also be included. • The wording does not address reporting duplications. • Clear definitions and patient-centred focus should be considered.

Priority Area 7: Vaccine-preventable Diseases Surveillance

Surveillance was indicated as administratively burdensome, as some PTs face capacity issues. Participants also discussed data quality, privacy, and population representation. Data governance was noted as being particularly important for Indigenous Peoples and other racialized and marginalized populations.

Revised Proposed PA7: Vaccine-preventable Diseases Surveillance	
Topic	**Points raised**
Administration	• The same data is provided multiple times to the federal level. • P/Ts need more time for data collection to meet tight federal timelines for reporting. • P/Ts already have their own vaccine-preventable databases, and it is unclear if this PA is meant for the federal or PT level.
Data	• Data should also be collected on emerging diseases that are not yet considered VPDs, disease burden, and vaccine effectiveness. • Tracking of unexpected events would help address other issues; the example of a vaccine that decreased gonorrhea was noted. • It may be useful to collect disease information and distribution before a vaccine has been approved and implemented, especially if it is higher in the vaccine pipeline. • Consider Indigenous data sovereignty. • Veterinary surveillance and grounding in One Health should also be considered.
Priority populations	• Data collection for remote populations can take more time and should be considered in planning. • Proxies are often used for some identities, such as Inuit, and partnerships are needed to ensure accuracy. • Unhoused populations are often not represented in data and can be overlooked, while experiencing disproportionate impacts of some diseases, such as pneumococcal disease
PA language	• An evaluation component could be added to assess surveillance methods. • Specific examples such as sero-epi may not be necessary to include.

Priority Area 8: Case, Contact, and Outbreak Management of Vaccine-preventable Diseases

Participants noted clarity is needed around federal and P/T jurisdictions and funding. A number of concepts were noted as missing, such as public communications. There was also disagreement around using terms "culturally sensitive" or "culturally appropriate."

Revised Proposed PA8: Case, Contact, and Outbreak Management of VPDs	
Topic	**Points raised**
Jurisdiction	• The reference to borders implies geography and should encompass other aspects. • Guidance documents are needed to enable appropriate and timely responses from P/Ts. • Responsibility for case management during inter-provincial movement requires clarification. • A guidance document is needed for P/T roles and responsibilities.
Implementation	• There are discrepancies between P/Ts because of a lack of standard case definitions for specific diseases. • Cross-provincial coordination is needed to focus on contact management for cross-provincial residents. • It can be difficult for P/Ts to keep up with NACI guidance. • There is a disconnect between guidance documents and frontline implementation.
Missing concepts	• Include other communicable diseases, data sharing, equity, supply management, and public communications.
Priority populations	• The PA requires building trust, especially for remote communities. • Some new surveillance methods are not available to all communities, such as wastewater.
PA language	• References to "Canada" could be problematic as funding is different across the country, and in this context may mean not just the federal government. • A reference to timeliness could be included.

Priority Area 9: Vaccine Confidence and Uptake

It was noted that the PA seemed to reflect an individual or community responsibility for gaps in vaccine uptake, rather than systemic issues. Community engagement may not be sufficient to influence confidence and uptake, and may instead require community leadership, especially in support of Indigenous community leadership.

The difference between vaccine access and vaccine uptake was also discussed, and that it is problematic to treat them as the same concept. It was also indicated that education is not enough, as it was felt that the pandemic showed that telling people they need to become better informed does not advance the confidence discussion.

Revised Proposed PA9: Vaccine Confidence and Uptake	
Topic	**Points raised**
Acknowledge systemic issues	• Public health needs to address the systems side of vaccine confidence in changing individual behaviours. • Community-centred may not be the same thing as culturally safe or culturally appropriate. • Systemic barriers to vaccination need to be reduced.
Access and uptake are distinct	• Access cannot be combined with uptake or confidence—people can be confident, but may not have access to providers. • The PA seems to imply confidence is causal to uptake, but they are each two separate measurable variables. • Uptake is influenced by more than just confidence.
Priority populations	• Culturally safe immunization spaces relates to more than Indigenous populations. • We must not lose sight of how we deliver information to various different groups—they may not seek out the same facts or sources, and are not influenced by the same campaigns.
PA language	• The focus on hesitancy could be replaced with structural barriers to access and uptake. • Wording should reference trust.

Priority Area 10: Vaccine Supply

It was noted that manufacturers are currently driving the research and development agenda, and that there should be a united voice representing Canada to engage with the manufacturer. Participants also discussed challenges with inventory management, and lack of funding. It was also felt that this PA was unclear with terminology and the distinction between vaccine research and development, and production.

Revised Proposed PA10: Vaccine Supply	
Topic	**Points raised**
Inventory management	• A digital system should be considered, given the difficulty of inventory management. • Each jurisdiction has its own process, and NACI would need to provide guidance to aid in coordination. • This PA should refer to all vaccines, such as for travel, and not just those in public health programs. • There are opportunities for bulk procurement, regardless of vaccine source. • Safe supply and equitable supply are also important.
PA language	• It is unclear if the word "affordable" may really mean "cost-effective." • The PA should clarify if its intent is to increase manufacturing within Canada.

Priority Area 11: Vaccine Innovation, Research, and Development

The roles of various groups in research and development were discussed, such as academic, industry, and communities. Distinguishing this priority areas 4 and 10 was also noted as important, as participants perceived some overlap.

Some participants felt public health goals and outcomes need stronger representation in the research and manufacturing space. The link to domestic manufacturing could also be strengthened.

Revised Proposed PA11: Vaccine Innovation, Research, and Development	
Topic	**Points raised**
Manufacturing	• Elaboration and context is required for manufacturing, given the current call for domestic emphasis and need for capacity building. • Clarification is required as to whether the focus is infrastructure or development.

	• Consider adding biomanufacturing and reference to Canada Biomanufacturing Lifesciences Strategy.
Public health presence	• A stronger public health voice could steer discourse from industry pushing back against domestic manufacturing. • There is misalignment with public health goals and industry-led research and development. • There is a need for a clear process to respond to public health priorities. • Program innovation should also be considered, not just technological.
Priority populations	• Community needs of different population groups should be mentioned, not just broad public health needs. • Lived experiences, ethics, and community guidance should be included.
PA language	• Incorporate specific language for OCAP© principles. • Addressing equity should be included. • Consider that discourse around early vaccination rollout to Indigenous populations can sound like "testing." • Wording to reference domestic use and creating an attractive research environment could be included. • It could be clearer what research in this PA context means.

*First Nations principles of data and research Ownership, Control, Access and Possession;

Priority Area 12: No-fault Injury Support

Participants indicated that there is fragmentation in vaccine safety systems and information sharing. They also noted that administering the existing support system can be burdensome to providers and the client.

It was suggested that trust could be built by providing data on how many people were compensated to show there is a legitimate source of support; however, on the other hand, it was also noted that the existence of this program could imply there is a problem with vaccines and impact vaccine confidence.

Revised Proposed PA12: No-fault Injury Support	
Topic	**Points raised**

Disconnection	• Many people may not be aware that a system for support already exists; better communication and awareness is required. • Information systems are not interconnected and there needs to be more multidirectional information sharing. • It is unclear how the program interacts with individual litigation. • There could be more clarity about the program having eligibility criteria and assessment requirements.
Administrative burden	• The process to access support should be easy, but the client is not being supported if the administration takes a long time. • Some providers are charging fees to prepare and provide documentation.
Priority populations	• More information is needed to determine if there are populations disproportionately impacted, such as any populations that may have mandated vaccination.
PA language	• Measurement and evaluation could be included. • It is difficult to define and determine what is fair, equity-informed, and efficient. • It could be noted that injury is unintended. • A reference to timeliness could be included.

Conclusion

Summary of Key Findings

Discussion and feedback consistently illustrated several themes shared across groups.

- ❖ Clarity and definitions—lack of specific word definition or what was meant within the particular PA context was noted for most PAs. The relationship between several PAs was perceived to overlap. Including a glossary was a common suggestion.

- ❖ First Nations, Inuit and Métis peoples and their perspectives are missing—discussion for all PAs and in some plenary settings raised concerns regarding the lack of incorporating Indigenous People's involvement in both the development of the NIS and visibility in the PAs themselves. There was also a lack of consensus about the appropriateness of certain words and terms, such as equity, culturally appropriate or culturally sensitive, and whether they should be used in the PAs.

- Jurisdiction roles—discussion about many PAs referenced challenges between federal-PT responsibilities and expectations. Participants were looking toward federal counterparts for leadership in addressing these challenges, and seeking clarity on which level of authority the PAs were acting.

The implications of these themes for next steps in strategy development and implementation include:

- If words, terminology, and language are not readily understood for their intended meaning within the context of the Strategy, the Strategy is at risk of being interpreted or applied inconsistently. It may also embed assumptions in the Strategy that may not apply to all jurisdictions or populations in the same magnitude or in the same manner.

- The Summit itself included Indigenous participation and voices, but the strategy runs the risk of not reflecting this population appropriately. Participants provided a number of real-world concerns about lived experiences, colonialism, and data sovereignty related specifically to immunization that may require further intentional incorporation into the Strategy.
- The Strategy will be successful through coordination and harmonization, and each level of authority will need to be clear as to their role and responsibility. Participants are looking for leadership and direction, and a mindful approach to implementation.

- The public health community has an opportunity through the Strategy to impact, influence, and link a wide range of health systems and services and all levels of authority. Participants discussed a variety of considerations that accompany, or extend beyond, a vaccine or disease in and of itself--social, technological, economic, capacity, political, and equity are all important factors and drivers. The nature of population and public health as a discipline is positioned to recognize and address these drivers, especially given the need to combat the current environment of rising misinformation and erosion of trust in vaccination.

Appendix A

A. Participant Agenda